

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005836

STATE FILE NUMBER

Registration District No. 86Primary Registration District No. 5329Registrar's No. 10-1963DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/5962806280

3

4 05 2

6

7 18 09331X

10

11

1290-0131-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>STANFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>STANFORD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba Oakhill Twnsh</u>		Length of stay in 1b	c. CITY OR TOWN <u>Cuba, Mo.</u>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>TR. # 2, Cuba, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Rte 2</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S</u> Last <u>Russell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McCallerton Trucking Co</u>	11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>
13a. FATHER'S NAME <u>William Thaddeus Russell</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Bleeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		16. SOCIAL SECURITY NO. <u>Service Members</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>20 yrs.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>3 p.m.</u> Month, Day, Year <u>Sept, 1958 to March 1, 1963</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Cuba, Mo.</u>	
21. I attended the deceased from <u>Sept, 1958 to March 1, 1963</u> and last saw her/him alive on <u>March 1, 1963</u> Death occurred at <u>3 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>May 2, 1963</u>	
22a. SIGNATURE <u>Frank A. Elders, M.D.</u> (Degree or title)		22b. ADDRESS <u>Cuba, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMBRY</u>	23b. DATE <u>May 2, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DAY RIDGE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>COOK COUNTY ILLINOIS</u>
24. FUNERAL DIRECTOR <u>Paul J. Franklin</u>		25. DATE RECD. BY LOCAL REG. <u>March 3, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Paul J. Franklin</u>			

(Licensed Embalmer's Statement on Reverse Side)

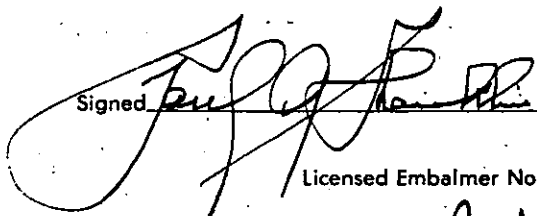
USE BLACK INK  
OR  
TYPEWRITER RIBBON

MAR 7 1963  
MAR 13 1963

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 3472

P. O. Address Cuba, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.